



## Parent Consent for Seasonal Influenza Vaccination

## FOR CLINIC USE ONLY

① ☐ M ☐ S ② ☐ VFC ☐ VAX ☐ STATE

Partner ID:

Partner Name:

Clinic ID:

School Name:

VaxCare has partnered with your healthcare provider to provide immunizations.

All bills for privately insured patients will come from either VaxCare or DHEC.

Consent ID:



## School and Student Information (use black ink only)

STUDENT FIRST NAME		MI	STUDENT LAST NAME		AGE	GRADE	GENDER: <input type="checkbox"/> M <input type="checkbox"/> F
DATE OF BIRTH (MM-DD-YYYY)		SCHOOL NAME		HOME ROOM TEACHER			
ETHNICITY: <input type="checkbox"/> Amer. Indian / Alsk. Native <input type="checkbox"/> Asian <input type="checkbox"/> Black / Afr. Amer. <input type="checkbox"/> Hawaiian / Pac. Islnd. <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Other							
STREET ADDRESS		APT/SUITE	CITY		STATE	ZIP	
PARENT/GUARDIAN FIRST NAME		PARENT/GUARDIAN LAST NAME		PARENT/GUARDIAN HOME PHONE:		PARENT/GUARDIAN CELL PHONE:	

## Insurance Information (Please fill out completely!)

<input type="checkbox"/> INSURANCE PAY	<input type="checkbox"/> Aetna <input type="checkbox"/> BCBS <input type="checkbox"/> CIGNA <input type="checkbox"/> Golden Rule <input type="checkbox"/> Mail Handlers <input type="checkbox"/> Med Mutual <input type="checkbox"/> Tricare <input type="checkbox"/> United Healthcare	
<input type="checkbox"/> Blue Choice <input type="checkbox"/> Carolina Care <input type="checkbox"/> Coventry <input type="checkbox"/> Humana <input type="checkbox"/> Medcost <input type="checkbox"/> PAI <input type="checkbox"/> UMR <input type="checkbox"/> Wellpath		
PRIMARY INSURANCE	MEMBER / INSURED ID#	GROUP ID
RELATIONSHIP TO THE SUBSCRIBER/INSURED: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	SUBSCRIBER/INSURED DOB (MM-DD-YYYY) GENDER: <input type="checkbox"/> M <input type="checkbox"/> F	

By signing below, I consent to the use and disclosure of my child's personal health information for the purpose of health care operations, along with the assignment of all payments from the insurer listed above to VaxCare for the services rendered. I understand I will be responsible for payment for the influenza vaccine if my insurance company does not pay. I acknowledge that I have been provided access to the VaxCare Privacy Notice for my review.

<input type="checkbox"/> MEDICAID STATE ID #	<input type="checkbox"/> NO INSURANCE I have no insurance or Medicaid coverage for my child
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By signing below, I request that payment of Medicaid benefits be made on my behalf to the South Carolina Department of Health and Environmental Control (DHEC) for any services provided to my child. I give DHEC permission to exchange my child's medical or other confidential information as necessary to the Centers for Medicare and Medicaid Services (CMS), its agents, or other agents needed to determine benefits related to services provided. I agree to participate in treatment plans and to assignment of Medicaid benefits to DHEC for services rendered. I acknowledge that I have been provided access to the DHEC Privacy Notice for my review.

## Authorization and Consent

**Consent for Use of Protected Health Information & Claims Assignment:** I hereby consent to the use and disclosure of my child's personal health information for the purpose of health care operations, along with the assignment of all payment from the insurer listed above to VaxCare or DHEC associated with the services contemplated herein. **Vaccine Authorization:** I consent for my child to receive the seasonal influenza vaccine at school. I have read the Vaccine Information Statement. I have had an opportunity to ask questions about the vaccine. I understand the risks and benefits of the vaccine. I understand that the vaccine may be given as a nasal spray or as a shot. I have read and answered the questions on the back of this form carefully and accurately, and I understand that incorrect information could cause serious risks to my child. I consent to my child receiving a second dose of the seasonal influenza vaccine at a school clinic if my child is less than 9 years old and a second dose is recommended by the U.S. Centers for Disease Control and Prevention (CDC). In case of occupational exposure, I consent to my child's blood testing if necessary for child and employee safety. I understand that immunization information about my child will be reported to the SC Immunization Registry for public health purposes. **I unconditionally and irrevocably waive any right to a trial by jury, to the maximum extent allowed by law, for any claim or action against VaxCare arising out of or related to this service, and that any such claim or action shall be determined solely on an individual basis through arbitration in accordance with Commercial Arbitration Rules of the American Arbitration Association. Neither I nor VaxCare shall be entitled to join or consolidate claims in arbitration by or against other individuals or entities, or arbitrate any claims as a representative member of a class or in a private attorney general capacity. The foregoing arbitration provisions do not affect or apply to any disputes with or claims by or against DHEC or any action to which DHEC is a party, regardless of whether VaxCare is also a party. DHEC does not consent to arbitration to resolve any claims, disputes, or actions. If consenting for another:** I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine administration.

SIGNATURE of PARENT or LEGAL GUARDIAN

DATE

**\*\* PLEASE TURN THE PAGE OVER AND COMPLETE SCREENING QUESTIONS ON BACK BEFORE RETURNING TO SCHOOL \*\***

## Vaccination Details (Influenza: VO4.81) FOR CLINIC USE - BLACK INK ONLY

FIRST DOSE	SECOND DOSE
<input type="checkbox"/> VFC <input type="checkbox"/> VAXCARE <input type="checkbox"/> STATE	<input type="checkbox"/> VFC <input type="checkbox"/> VAXCARE <input type="checkbox"/> STATE
MFR / LOT	MFR / LOT
<input type="checkbox"/> MI <input type="checkbox"/> SP <input type="checkbox"/> GSK	<input type="checkbox"/> MI <input type="checkbox"/> SP <input type="checkbox"/> GSK
LD <input type="checkbox"/> RD <input type="checkbox"/> Nasal <input type="checkbox"/> Other	LD <input type="checkbox"/> RD <input type="checkbox"/> Nasal <input type="checkbox"/> Other
"What to Know After," given to student	"What to Know After," given to student
Unable to vaccinate student due to "Unable to Vaccinate" form given to student	Unable to vaccinate student due to "Unable to Vaccinate" form given to student
DATE (MM-DD-YYYY)	DATE (MM-DD-YYYY)
NURSE SIGNATURE	NURSE SIGNATURE
PATIENT/STUDENT'S ASSIGNED CLASSROOM TEACHER SIGNATURE	PATIENT/STUDENT'S ASSIGNED CLASSROOM TEACHER SIGNATURE

Nurse: I hereby attest by signature above that the patient (or guardian of patient) in question has been given the Influenza Vaccine Information Sheets and has given written consent for vaccination.

Nurse: I hereby attest by signature above that the patient (or guardian of patient) in question has been given the Influenza Vaccine Information Sheets and has given written consent for vaccination.

Teacher: I hereby attest by signature above that the identity of the patient in question has been verified.

Teacher: I hereby attest by signature above that the identity of the patient in question has been verified.

**Influenza Vaccination:** The following questions will help us determine if there is any reason we should not give your child a seasonal influenza vaccination. If a question is not clear, please ask your healthcare provider to explain it. PLEASE ANSWER ALL QUESTIONS.

- |   |                                |                                 |
|---|--------------------------------|---------------------------------|
| 1. Has your child ever had a <u>serious reaction</u> to eggs OR a serious reaction to a previous flu vaccine that caused any of the following: wheezing, trouble breathing, hives and itching all over the body, swelling in the mouth or throat, very low blood pressure or shock? | NO<br><input type="checkbox"/> | YES<br><input type="checkbox"/> |
| <hr/>   |                                |                                 |
| 2. Has your child ever had Guillain-Barre Syndrome (a rare type of temporary severe muscle weakness and paralysis)?   | NO<br><input type="checkbox"/> | YES<br><input type="checkbox"/> |

**If you answered YES to any of the questions above, your child cannot receive the 2015-2016 seasonal influenza vaccine at school. Please contact your primary healthcare provider about the flu vaccine.**

**If you answered NO to the above questions, please complete the following additional questions:**

- |  |                                |                                 |                                    |
|--|--------------------------------|---------------------------------|------------------------------------|
| 3. Has your child received any vaccine(s) within the past 30 days? If yes, list:<br>Vaccine Name(s): _____ Date given: _____   | NO<br><input type="checkbox"/> | YES<br><input type="checkbox"/> |                                    |
| <hr/>  |                                |                                 |                                    |
| 4. Does your child have any of the following: asthma, diabetes (or other type of metabolic disease), seizures (or other type of neurologic or neuromuscular disorder), or disease of the lungs, heart, kidney, liver, or blood (including anemia)? | NO<br><input type="checkbox"/> | YES<br><input type="checkbox"/> |                                    |
| <hr/>  |                                |                                 |                                    |
| 5. Is your child receiving aspirin therapy or aspirin-containing therapy?  | NO<br><input type="checkbox"/> | YES<br><input type="checkbox"/> |                                    |
| <hr/>  |                                |                                 |                                    |
| 6. Does your child have a weak immune system? (For example, treatment for cancer or HIV/AIDS or taking medications such as steroids that may cause the immune system to be weak)   | NO<br><input type="checkbox"/> | YES<br><input type="checkbox"/> |                                    |
| <hr/>  |                                |                                 |                                    |
| 7. Is your child pregnant? (Please discuss this question with your child for verification)   | NO<br><input type="checkbox"/> | YES<br><input type="checkbox"/> |                                    |
| <hr/>  |                                |                                 |                                    |
| 8. Does your child have close contact with a person who needs care in a protected environment? (For example, someone who is in a bone marrow transplant unit.)   | NO<br><input type="checkbox"/> | YES<br><input type="checkbox"/> |                                    |
| <hr/>  |                                |                                 |                                    |
| 9. <b>If your child is 2-4 years of age</b> , has your child had a wheezing episode in the past 12 months?   | NO<br><input type="checkbox"/> | YES<br><input type="checkbox"/> |                                    |
| <hr/>  |                                |                                 |                                    |
| 10. <b>If your child is under 9 years old</b> , he/she may need 2 doses of flu vaccine.<br>Please provide your child's date of birth <u>ONLY</u> if your child is under 9 years old.   | DOB: ____/____/____            |                                 |                                    |
| <hr/>  |                                |                                 |                                    |
| 11. <b>If your child is under 9 years old</b> , has your child received at least two doses of influenza vaccine prior to July 1, 2015?   | NO<br><input type="checkbox"/> | YES<br><input type="checkbox"/> | UNSURE<br><input type="checkbox"/> |
| <hr/>  |                                |                                 |                                    |
| 12. Please provide your email address (optional):  | <input type="text"/>           |                                 |                                    |

Notes:



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2nd Dose Needed: ☐ Yes ☐ No